Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROCKWALL HEATH SURGERY CENTER
6435 SOUTH FM 549 SUITE 101
HEATH TX 75032

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-11-2011-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was paid incorrectly. We are disputing the non-payment of a portion of the charge of CLP L8699 for implants used in the procedure that is payable. This implant charge consists of 3-payable items, the allograft that was paid and the 2 -8x25mm screws that were not. The cost of the two screws was $125.61 each. The total still owed is $251.22 plus 10% interest equaling $276.34. The total allowed amount for the implant charge should be $3,411.34."

Amount in Dispute: $276.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The audit and reimbursement of the bill is based on the information provided by the health care provider. The number of units billed for this code was 1 and reimbursed $3,135.00 for the Bone Allograft paid @ 10%. The bill does not indicate 3-payable items/units on the CMS 1500." "The Office therefore will maintain that the original reimbursements made on this bill were correct and in accordance with the Divisions rules and payment policies."

Response Submitted by: SORM, P.O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2010	HCPCS Code L8699	$276.34	$276.34

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 17, 2011

   - W1-Workers compensation state fee schedule adjustment.
   - Only 1 reimbursement based on unit bill for implant amount of bone allograft paid @ 10%.

   Explanation of benefits dated February 3, 2011
   - W1-Workers compensation state fee schedule adjustment.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - The bill does not indicate 3-payable items/units on the CMS-1500 therefore only 1 reimbursement based on unit bill for implant amount of bone allograft paid @ 10%.

Issues

1. Did the requestor support position that additional reimbursement is due for HCPCS code L8699? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(B) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

   HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

   The respondent states in the position summary that "The audit and reimbursement of the bill is based on the information provided by the health care provider. The number of units billed for this code was 1 and reimbursed $3,135.00 for the Bone Allograft paid @ 10%. The bill does not indicate 3-payable items/units on the CMS 1500."

   The Division finds that the requestor's billing indicates that one unit of HCPCS code L8699 was billed for $3,619.34. The requestor's "APPEAL NOTICE," implant invoices, patient's implant charge sheet and operative report support that the implants used were a Bone Allograft and two (2) 8mm X 25 mm interference screws.

   The Division concludes that the requestor's documentation supports reimbursement for the disputed two (2) 8mm X 25 mm interference screws and Bone Allograft billed under HCPCS code L8699.

   28 Texas Administrative Code §134.402(f)(1)(B)(i) states " the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

The requestor submitted Smith & Nephew Endoscopy and MTF invoices that supports the following:

DESCRIPTION	COST	COST PLUS 10%	MAR
Bone Allograft	$2,850.00	$2850.00 + $285.00	$3,135.00
8mm X 25 mm interference screw	125.61 X 2 = $251.22	$251.22 + 25.12	$276.34
TOTAL			$3,411.34

The MAR for HCPCS code L8699 is $3,411.34. The respondent paid $3,135.00. The difference between the MAR and amount paid is $276.34. This amount is recommended for reimbursement for HCPCS code L8699.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $276.34.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $276.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/9/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.